TRICARE Prior Authorization Request Form for

ivacaftor/lumacaftor (Orkambi)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is Orkambi prescribed for the treatment of cystic fibrosis? **Note: Non-FDA-approved uses are not approved, including: patients who are heterozygous for the F508del mutation in the CFTR gene.**	☐ Yes Proceed to Question 2	☐ No **STOP** Coverage not approved
2. Is this request for Orkambi granules or tablets?	☐ Granules Proceed to Question 3	☐ Tablets Proceed to Question 5
3. What is the patient's age	☐ 1 to 5 years of age - proceed to Question 6 ☐ Older than 5 years of age – proceed to Question 4 ☐ Younger than 1 year of age – **STOP Coverage not approved**	
4. Does the patient have documented swallowing difficulties?	☐ Yes Proceed to Question 6	☐ No **STOP** Coverage not approved
5. Is the patient 6 years of age or older?	☐ Yes Proceed to Question 6	☐ No **STOP** Coverage not approved
6. Is the patient homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-approved test?	☐ Yes Proceed to Question 7	☐ No **STOP** Coverage not approved
7. Will the patient be using Orkambi granules along with Orkambi tablets?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to Question 8

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7. Will the requested medication be used in combination with ivacaftor (Kalydeco) or tezacaftor/ivacaftor (Symdeko)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[05 April 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: